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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on April 30 through May 2, 2024.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' rooms as evidenced by 5 of 5 fixtures with water temperatures ranging from 118.2 to 118.4 degrees F. The findings are: Observation of water temperatures on the A assisted living (AL) hall on 04/30/24 from 9:32am to 10:15am revealed: -The water temperature in the bathroom sink in room A13 was 118.4 degrees Fahrenheit (F). -The water temperature in the bathroom sink in room A6 was 118.2 degrees F. Observation of water temperatures on the Special Care Unit (SCU) on 04/30/24 from 10:16am to 10:22am revealed:	D 113		

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-The water temperature in the bathroom sink in room C2 was 118.4 degrees F.
-The water temperature in the bathroom sink in room C9 was 118.0 degrees F.
-The water temperature in the bathroom sink in room C15 was 118.2 degrees F.

Second observation of water temperatures on the SCU on 04/30/24 from 3:45pm to 3:38pm revealed:
-The water temperature in the bathroom sink in room C2 was 115.2 degrees F.
-The water temperature in the bathroom sink in room C15 was 114.2 degrees F.

Third observation of water temperature in the facility on 05/01/24 from 7:58am to 8:08am revealed:
-The water temperature in the bathroom sink in room A6 was 112.6 degrees F.
-The water temperature in the bathroom sink in room A13 was 113.4 degrees F.
-The water temperature in the bathroom sink in room C2 was 112.6 degrees F.
-The water temperature in the bathroom sink in room C15 was 112.5 degrees F.

Interview with the resident in room A6 on 04/30/24 at 9:40am revealed:
-She had not noticed the water in the bathroom being too hot.
-She could turn on the cold faucet if she needed to adjust the water temperature.

Interview with a personal care aide (PCA) working in the SCU on 04/30/24 at 10:24am revealed:
-She had not noticed the water temperatures in the residents' rooms being too hot.
-She always checked the water temperature on her wrist before assisting a resident into the

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shower.
-She used the cold and hot water faucets to adjust the water temperatures in residents' rooms.
-If she noticed any issues with the water temperature, she would report it to the Maintenance Director.

Interview with the Maintenance Director on 04/30/24 at 10:28am revealed:
-He usually checked the water temperatures in the facility every week.
-He had not checked water temperatures this week.
-He thought the range for water temperatures in residents' rooms should be 107-112 degrees F.
-He had not noticed any elevated water temperatures in residents' rooms when he checked the water temperatures.
-He had not received any reports of elevated water temperatures from residents or staff.
-If he checked a water temperature and it was elevated, he would report the elevated temperature to the Administrator.
-He could attempt to adjust the water heaters and call a plumber if needed.

Review of the facility's water temperature logs from January 2024-April 2024 revealed:
-On 01/06/24, five fixtures were checked, including one resident's room fixture, and the temperature was 113 degrees F.
-On 02/01/24, five fixtures were checked, including two residents' room fixtures, and ranged from 110.8-111 degrees F.
-There were no water temperature logs for March 2024.
-On 04/12/24, five fixtures were checked, including one resident's room fixture, and the temperature was 113 degrees F.

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-On 4/22/24, five fixtures were checked including two residents' room fixtures, and the temperatures ranged from 111.5-112 degrees F.

Second interview with the Maintenance Director on 05/01/24 at 9:00am revealed:
-He adjusted the temperature on the water heater on 04/30/24.
-He checked several residents' rooms after he adjusted the water heater temperature and did not have any readings over 116 degrees F.
-He did not have any water temperatures recorded for March 2024.
-His work cell phone had a software application and he sometimes entered water temperatures into the application.
-All the water temperature readings he entered into the application were not saved in the application, so he did not have those water temperature readings.

Interview with the Administrator on 04/30/24 at 10:32am revealed:
-The facility had contacted a plumber to adjust the water temperature sometime in the last month.
-She was unsure of the date the plumber adjusted the water temperature.
-She thought the water temperature in residents' rooms should be around 107 degrees F, but she was unsure of the exact range.
-The Maintenance Director was responsible for checking the water temperatures in the facility.
-She was unsure how often the Maintenance Director checked the water temperatures.
-The Maintenance Director used a software application to track water temperatures and other maintenance tasks.
-She was concerned that the elevated water temperatures in the residents' rooms could be

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D 113	Continued From page 4 harmful to the residents. -The facility could attempt to adjust the water temperature and recheck the water temperatures in the residents' rooms. Second interview with the Administrator on 05/02/24 at 3:00pm revealed: -She was unsure how many times each month the Maintenance Director should check water temperatures in the facility. -She thought the water temperature should be checked at least weekly to ensure the water was maintained at a safe temperature. -She did not review information the Maintenance Director entered into the software application. -She was unsure if the Maintenance Director had an alternate method of recording the water temperature readings. -She was concerned that residents could be burned by hot water if the temperature was too high.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure personal care needs were being met as related to toenail care for 1 of 5 sampled residents (#2).	D 269		

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D 269	Continued From page 5 The findings are: Interview with the Administrator on 05/02/24 at 11:08am revealed the facility's policy and procedure for nail care only referred to fingernails and did not specify toenail care. Review of Resident #2's current FL-2 dated 04/24/24 revealed diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety disorder. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 02/01/18. Review of Resident #2's current care plan dated 01/31/24 revealed: -Resident #2 was ambulatory without problem and "pleasantly confused". -She was incontinent of bowel and bladder. -She was always disoriented and had significant memory loss. -Resident #2 required limited staff assistance with bathing, dressing, grooming, and personal hygiene. Review of the undated Special Care Unit (SCU) AM Shower Schedule revealed Resident #2 was scheduled every Tuesday and Friday morning for shower assistance. Review of Resident #2's shower sheets dated 03/01/24 through 04/05/24 revealed: -There was documentation of the following: on 03/01/24, 03/05/24, 03/08/24, 03/12/24, 03/15/24, 03/22/24 and 04/05/24, Resident #2 was assisted with a shower and nails (unspecified) were cleaned and not trimmed, -On 03/19/24 Resident #2 was assisted with a	D 269		

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shower and her nails were cleaned; there was no mark next to yes or no for nails trimmed.
-On 03/26/24, Resident #2 was assisted with a shower and nails (unspecified) were cleaned and not trimmed.

Review of Resident #2's February and March 2024 Monthly Task Logs (Activities of Daily Living - ADLs) revealed:
-There was an entry for physical assistance was provided for dressing with documentation the task was completed twice daily from 02/01/24 through 03/31/24.
-There was an entry for physical assistance was provided for grooming and personal hygiene with documentation the task was completed twice daily from 02/01/24 through 03/31/24.
-There was an entry for skin checks conducted with routine bath/shower and staff would report impairments.
-There was documentation of completed skin checks every Tuesday and Friday from 02/01/24 through 03/31/24.
-There was no entry for toenail care.

Review of Resident #2's electronic progress notes dated from 11/10/23 through 03/29/24 revealed:
-There was no documentation of Resident #2's toenails, care of toenails, or notification to the primary care provider (PCP) about Resident #2's toenails from 11/10/23 through 03/28/24.
-On 03/29/24, a medication aide (MA) documented the HWD, Resident Care Coordinator (RCC) and 2 MAs assisted Resident #2 with cutting her toenails.

Review of Resident #2's PCP visit notes dated 10/25/23 through 03/27/24 revealed:
-There were visit notes dated 10/25/23, 11/15/23,

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D 269	Continued From page 7 11/22/23, 11/29/23, 01/31/24, 02/02/24, 03/13/24, and 03/27/24. -There was no documentation related to Resident #2's toenails. Telephone interview with Resident #2's family member on 04/30/24 at 4:09pm revealed: -Resident #2 fell and broke her nose on 03/28/24. -The family member saw Resident #2's bare feet while she was in the emergency room (ER). -Resident #2's toenails looked like "falcon's talons" because the toenails were so long, they curled over the toes. -The family member took pictures and asked staff on the SCU how Resident #2's toenails got that long. -Staff claimed they cut Resident #2's toenails every month. -Resident #2 needed staff to assist with walking, bathing, and dressing. -It took months for Resident #2's toenails to grow that long. Interview with a personal care aide (PCA) on 05/01/24 at 3:07pm revealed: -PCAs checked residents' toenails when the resident was assisted with bathing on shower days. -PCAs did not cut residents' toenails; a provider came to the facility and cut residents' toenails. -PCAs documented if a resident needed their toenails clipped on the shower sheet. -PCAs completed a shower sheet for each resident on their shower days. -Completed shower sheets were put in the folder at the front desk for the medication aide (MA) to sign. Interview with a second PCA 05/02/24 at 12:24pm revealed:	D 269		

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-PCAs checked residents' toenails daily either with dressing and/or bathing.
-PCAs cut residents' toenails as needed except for residents with diabetes.
-She saw the picture taken by the family member of Resident #2's toenails and did not remember seeing the resident's toenails like prior to the picture.
-She rarely assisted Resident #2 with showering and dressing.

Interview with a third PCA on 05/02/24 at 12:39pm revealed:
-She assisted Resident #2 with showers a few times before 03/28/24.
-She checked residents' feet when she assisted them with showers.
-She did not notice Resident #2's toenails had grown over her toes.

Interview with a MA on 05/02/24 at 2:35pm revealed:
-No one had reported Resident #2's toenails to her prior to the family reporting the toenails on 03/28/24.
-Every Tuesday on the Special Care Unit (SCU) there was a facial hair, fingernail, and toenail activity.
-Staff assisted residents with tweezing and shaving facial hair, trimming, filing, and painting fingernails, and trimming and filing toenails.
-Resident #2 did not participate in activities and spent most of her time in her room.
-Prior to discovering Resident #2's overgrown toenails, MAs did not routinely check the toenail care needs of residents who were not at the activity.
-She checked residents listed for showers on the schedule for evidence of being showered such as wet hair and how the resident smelled.

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-She reviewed shower sheets, checked for any bruises or skin tears, signed the shower sheet and filed it in the binder at the front desk.

Interview with the Memory Care Director (MCD) on 05/01/24 at 3:51pm revealed:
-She did not know how Resident #2's toenails grew long enough to curl over her toes.
-She did not know Resident #2's toenails needed to be cut prior to 03/28/24.
-Staff did not report Resident #2's toenails nor document the toenails on the shower sheets.
-She did not routinely do skin and nail checks for residents on the SCU unless the resident was out of the facility with family or in the hospital.
-She checked residents' skin and nails when the resident returned to the facility.
-She did not know of Resident #2 being out of the facility in the few months before 03/28/24.
-She found out about Resident #2's overgrown toenails when the family member reported the toenails to her.
-PCAs were responsible for checking residents' toenails when the resident was assisted with bathing and dressing.
-A provider came to the facility every month to provide toenail care to residents.
-She did not know if Resident #2 was signed up for the podiatry service.
-The podiatry service required consent and approval of an additional charge by the resident's Power of Attorney (POA).
-The HWD cut Resident #2's toenails the same day the family reported the toenails being long.

Telephone interview with Resident #2's POA on 05/02/24 at 1:43pm revealed:
-She thought she paid $40.00 every 1-2 months for podiatry services for Resident #2 prior to an insurance change.

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-She no longer had to pay for podiatry services after Resident #2's insurance changed.
-The last time she was billed and paid for podiatry services was in July 2023.
-No one told her they were unable to cut Resident #2's toenails.
-A family member sent her the picture of Resident #2's toenails while the resident was at hospital.
-She spoke with the MCD and HWD and was told they would take care of Resident #2's toenails.

Telephone interview with Resident #2's PCP on 05/01/24 at 1:16pm revealed:
-She visited residents at the facility every week.
-She and staff had cut residents toenails at times and a podiatrist provided toenail care at the facility.
-She did not cut Resident #2's toenails.
-She cut the toenails of residents who resisted or protested when the podiatrist visited.
-Staff told her when residents resisted or protested toenail care from the podiatrist.

Second telephone interview with Resident #2's PCP on 05/02/24 at 11:37am revealed:
-She did not know if staff were supposed to document and notify her if a resident resisted or protested toenail care by the podiatrist.
-She thought staff needed a written order to cut a resident's toenails.
-She saw Resident #2's toenails on more than one occasion.
-She did not have the equipment to cut Resident #2's toenails when she saw them.
-She did not know how long it took for toenails to grow curling over the toe.

Interview with the HWD on 05/02/24 at 5:33pm revealed:
-She was shocked when saw Resident #2's

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toenails in the picture sent to her by the resident's POA.
-No one had documented Resident #2's toenails needing to be cut on shower sheets and no one reported it.
-She asked staff if they were checking Resident #2's toenails when they assisted with bathing and dressing and staff said nothing.
-Resident #2 was receiving services from the previous podiatrist last year.
-The previous podiatrist did not visit the facility for 2 months so they sought services from a new podiatry provider.
-Resident #2 was not signed up for services with the new provider.
-Resident #2's PCP cut residents' toenails in the time between podiatry providers.
-MAs or the MCD reviewed completed shower sheets.
-The completed shower sheet was brought to her for review by the MCD if a skin impairment such as bruise or wound was found.
-Completed shower sheets were kept for 30 days in the binder at the front desk and then discarded.
-It was unacceptable that PCAs saw Resident #2's toenails and did not report them.

Interview with the Administrator on 05/02/24 at 2:53pm revealed:
-A podiatrist came to the facility to provide toenail care because staff did not cut toenails.
-Residents in need of toenail care were referred to a provider.
-Resident #2's toenails were grossly overgrown because PCAs neglected to do the necessary screening and reporting.
-Staff were expected to get Resident #2 up to participate in care related activities.
-Residents were showered 2-3 times per week and PCAs were responsible for completing a

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D 269	Continued From page 12 shower sheet for every shower. -The HWD was responsible for reviewing completed shower sheets and conducting audits to ensure accuracy of what was documented on the shower sheets. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a physical and occupational therapy evaluation and the follow up orthopedic appointment in a reasonable time frame following a wrist fracture for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 04/24/24 revealed diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety disorder. a. Review of Resident #2's Home Health (HH) Referral Order Form dated 11/15/23 revealed: -Resident #2 was referred for physical therapy (PT) and occupational therapy (OT) with a diagnosis of a fractured right wrist. -The referrals were for gait/balance, therapeutic exercises/activity, and activities of daily living	D 273		

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(ADLs).

Review of Resident #2's HH Referral Order Form dated 11/29/23 revealed:
-Resident #2 was referred for PT/OT services due to a contracted left hand and casted right hand.
-The referrals were for gait/balance, therapeutic exercises/activity, restore function, and ADLs.
-Resident #2 diagnoses included falls, dementia, osteoarthritis, osteoporosis, and osteopenia.

Review of Resident #2's record on 04/30/24 revealed there was no documentation of a PT/OT evaluation dated after 11/15/23.

Review of Resident #2's primary care provider (PCP) visit note dated 11/15/23 revealed:
-Resident #2 required PT/OT due to increased physical instability, generalized weakness, and difficulty performing daily routines.
-Resident #2 recently fell (11/10/23) which resulted in a fractured right wrist.
-Resident #2's right wrist would be casted until January 2024, and the resident's left hand had contractures.
-Resident #2 suffered from osteoarthritis, osteopenia, and osteoporosis which put her at risk for additional broken bones.

Review of Resident #2's PCP visit note dated 11/29/23 revealed:
-Resident #2 required PT/OT due to increased physical instability, generalized weakness, and difficulty performing daily routines.
-Resident #2 recently fell (11/10/23) which resulted in a fractured right wrist.

Upon request on 04/30/24, 05/01/24, and 05/02/24, Resident #2's emergency room

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discharge instructions dated 11/10/23 were not provided for review.

Review of Resident #2's electronic progress notes dated 11/16/23 through 01/29/24 revealed:
-On 01/29/24, Resident #2's cast was removed from her right wrist.
-There was no documentation of follow up on Resident #2's PT/OT referrals dated 11/15/23 and 11/29/23.

Telephone interview with Resident #2's family member on 05/01/24 at 2:15pm revealed:
-She and the Health Care Power of Attorney (HCPOA) were not included in the care planning process, and they were told about PCP visits.
-There was no communication from staff about Resident #2's care and needs.
-She did not think Resident #2 had PT/OT after fracturing her wrist in November 2023.

Interview with the Memory Care Director (MCD) on 05/01/24 at 3:51pm revealed:
-She remembered Resident #2 having PT after she broke her wrist.
-Resident #2 broke her wrist twice since she was admitted to the facility (2018).
-She was not certain if Resident #2 had PT both times.
-The Health and Wellness Director (HWD) was responsible for clinical related matters including referral appointments.

Telephone interview with a Clinical Manager (CM) at the HH agency on 05/02/24 at 11:10am revealed:
-The HH agency received the PT and OT referral dated 11/15/23 for Resident #2.
-She did not have a record of the HH agency receiving a PT/OT referral dated 11/29/23 for

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D 273	Continued From page 15 Resident #2. -The HH agency did not admit Resident #2 for PT/OT services on 11/16/23 because they were unable to contact a family member for consent. -Resident #2 was unable to give consent. -The HH clinician spoke with staff on 11/16/23 and notified Resident #2's PCP about the inability to obtain consent for services. Telephone interview with Resident #2's PCP on 05/02/24 at 11:37am revealed: -Referrals for PT and OT had to be rewritten if the home health (HH) agency was unable to reach the family, the resident went to the hospital and the referral expired after 7 days or so. -She did not remember the details of what happened with Resident #2 in November 2023. -The HH agency would have known about the PT/OT referral dated 11/29/23 because the referral was made when the HH agency was at the facility. -She, the HWD, and the HH agency met weekly to discuss continual care needs for residents of the facility. -The HH provided the referral form, and she signed the referral order. -She did not know why there was no follow up on the PT/OT referral, but the HH agency knew about the referral dated 11/29/23 for Resident #2. Interview with the HWD on 05/02/24 at 5:33pm revealed: -The PCP signed the order on the HH agency's referral form. -The HH agency took a picture of the order and documented their own progress notes on any referrals. -Normally, the HH agency told her if they were unable to contact the resident's family member, otherwise, she did not follow up on HH referrals.	D 273		

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-She did not know if the HH agency told her they were not able to contact Resident #2's family member for the PT/OT referral dated 11/29/24.
-She kept notes on a Resident At Risk Tracking form for each resident discussed during the weekly meeting with the PCP and HH agency..

Review of the Resident At Risk Tracking form dated for the week of 11/29/23 revealed Resident #2 was not listed.

Interview with the Administrator on 05/02/24 at 2:53pm revealed:
-The HH agency, PCP, HWD and MCD had weekly meetings to discuss the needs of residents.
-Orders including PT/OT referrals were written during the weekly meeting.
-Everyone present at the weekly meeting was responsible for taking notes and follow up.
-The HH agency should have contacted Resident #2's POA for consent and completed an assessment for any needed services.
-Follow up on the PT/OT referral dated 11/29/24 should have been discussed at the next weekly meeting.
-Resident #2's PCP would have been responsible for follow up with the HH agency and the HWD was responsible for documenting follow up in Resident #2's electronic progress notes.

b. Review of Resident #2's electronic progress notes dated 11/10/23 through 11/15/23 revealed:
-On 11/10/23, Resident #2 fell and was sent to the emergency room (ER).
-On 11/11/23 at 12:30am, Resident #2 returned to the facility with a diagnosis of a closed right wrist fracture and a soft cast on her right arm.
-On 11/15/23, the Memory Care Director (MCD) documented Resident #2 had a follow up

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appointment on 11/16/23 at 2:30pm.
-The MCD was unable to reach Resident #2's Health Care Power of Attorney (HCPOA) and contacted the resident's Power of Attorney (POA).
-The POA said she would contact the HCPOA about the appointment.

Upon request on 04/30/24, 05/01/24, and 05/02/24, Resident #2's emergency room discharge instructions dated 11/10/23 were not provided for review.

Review of Resident #2's electronic progress notes dated 11/16/23 through 11/20/23 revealed:
-On 11/16/23, Resident #2's orthopedic follow up appointment was rescheduled for 11/20/23 at 1:50pm and the resident's HCPOA was aware.
-On 11/20/24, Resident #2 was seen at the orthopedic office and returned with a hard cast.
-Resident #2 had a follow up appointment on 01/02/24 at 2:30pm.

Review of Resident #2's electronic progress notes dated 12/26/23 through 01/29/24 revealed:
-There was no entry between 12/26/23 and 01/10/24.
-On 01/10/24, the HCPOA contacted the MCD to reschedule the orthopedic appointment that was scheduled for that day (01/10/24).
-Resident #2 was rescheduled for 01/15/24 at 3:20pm.
-On 01/15/24, Resident #2's orthopedic appointment had to be rescheduled because the HCPOA was unable to attend.
-On 01/16/24, the Health and Wellness Director (HWD) attempted to contact Resident #2's HCPOA to reschedule the orthopedic appointment for removal of the cast.
-On 01/16/24, the HCPOA told the HWD he rescheduled Resident #2's orthopedic

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appointment.
-There was no documentation when the appointment was rescheduled for.
-On 01/24/24, the HWD contacted Resident #2's POA regarding the orthopedic appointment.
-On 01/29/24, Resident #2 was seen at the orthopedic office and had the cast removed.

Telephone interview with a patient services coordinator at Resident #2's orthopedic physician's office on 05/02/24 at 1:29pm revealed:
-Resident #2 was a no show on 01/02/24.
-Resident #2 was last seen on 01/29/24 and did not have any future appointments scheduled.

Telephone interview with Resident #2's family member on 05/01/24 at 2:15pm revealed:
-She was Resident #2's HCPOA's partner.
-The facility did not have transportation to and from appointments or to pick up residents when they were discharged from the hospital.
-He was not always able to leave work for appointments and transport.

Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37am revealed:
-She did not know the exact date Resident #2 had the cast removed from her arm.
-Resident #2's orthopedic follow up appointment was delayed because a family member was not able to go with the resident to the appointment.
-A family member needed to attend appointments with residents of the Special Care Unit (SCU) due to the resident having dementia
-It would have been more problematic for a cast to be removed too early than too late because it would have been difficult to get a resident with dementia to wear a sling when the cast came off.

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D 273	Continued From page 19 Telephone interview with Resident #2's POA on 05/02/24 at 1:43pm revealed: -Resident #2 had a family member that was local to the facility and was the Health Care Power of Attorney (HCPOA) and primary contact person for Resident #2. -Staff could not always get in contact with Resident #2's HCPOA so she told them to call her first and she would handle whatever needed to be done. -She asked the MCD and HWD if she could pay someone to take Resident #2 to her appointments because of all the missed orthopedic appointments. -Resident #2 needed her follow up appointments because it was important for her wellbeing. -The MCD and HWD had to check with a manager before telling her paying for transport to appointments could not be done because someone had to stay with Resident #2 at the appointment. Interview with the MCD on 05/02/24 at 4:16pm revealed: -She did not know why Resident #2 did not go to the orthopedic appointment on 01/02/24. -Normally she wrote a note and there was no note by her which meant she might not have known about Resident #2's 01/02/24 orthopedic appointment. -Staff never accompanied SCU residents to appointments. -Staff drove residents to appointments and met a family member at the appointment. -Resident #2 missed multiple orthopedic appointments because her HCPOA did not show up for the appointment. Interview with the HWD on 05/02/24 at 5:33pm	D 273		

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D 273	Continued From page 20 revealed: -She scheduled Resident #2's orthopedic appointment for 01/02/24; she could not remember what happened. -She resolved the issue of getting Resident #2 to the orthopedic appointment by contacting the resident's POA. -The facility did not have the staff to sit all day at appointments with Resident #2. -She did not know if a home health (HH) agency or outside transportation was an option for Resident #2's medical appointments. Interviews with the Administrator on 05/02/24 at 2:53pm and 6:33pm revealed: -The facility provided transportation to and from appointments but did not stay with residents during appointments. -Residents on the SCU required the presence of a family member. -She did not know what was done when a resident did not have a family member. -She was told about Resident #2's missed orthopedic appointments. -The HWD and MCD contacted Resident #2's POA to get involved (01/24/24) because the resident's HCPOA was not showing up for scheduled appointments. -There was not enough staff to leave the facility and stay with Resident #2 at appointments. -She did not know Resident #2's POA requested a paid service for appointments, or she would have referred the POA to a home health agency. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 273		

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents on the Special Care Unit (SCU) (#2 and #4) right to associate and communicate privately and without restriction with family members at reasonable hours on the SCU.

The findings are:

Review of the facility's Visiting Hours section of the Resident Contract revealed:
-The Community front door was open from 9:00am until 7:00pm, Monday through Sunday.
-Visiting hours were not set, but preferred while the front door was open.
-Visitors were asked to sign the guest register.
-Guests were expected to respect all residents and staff and would be asked to leave the community if they failed to do so.
-There was no documentation specific to visitation on the Special Care Unit (SCU).

Observation on entry to the facility on 04/30/24 at 8:50am revealed:
-There was a vestibule upon entering the front door with sign in materials.
-A second entrance door opened to a foyer with 3 chairs, a coffee table and fireplace.
-There were 2 office doors, entrance to the remainder of the facility, and a glass door to a

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living room common area.
-There was a second door to the hallway from the living room common area.
-The living room common area was enclosed with windows on every wall and both doors.

1. Review of Resident #2's current FL-2 dated 04/24/24 revealed diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety disorder.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 02/01/18.

Review of Resident #2's electronic progress note dated 04/23/24 revealed Resident #2 visited with a family member in the front common area of the facility at 5:00pm.

Telephone interview with Resident #2's family member on 05/01/24 at 2:15pm revealed:
-She was Resident #2's Healthcare Power of Attorney's (HCPOA's) partner.
-Resident #2's HCPOA was not able to visit regularly due to his work schedule.
-The HCPOA visited Resident #2 twice since 03/28/24.
-Both visits were in the foyer at the front of the facility.
-She and the HCPOA were told it was a company policy that visitors were not allowed on the Special Care Unit (SCU).
-She was concerned about Resident #2's appearance each time they visited.
-Resident #2 looked disheveled, her hair was not combed, and she was not wearing her own clothes.
-In November 2023 when the weather was cold, Resident #2 went to the emergency room (ER)

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and was sent without a coat.
-Resident #2 was always cold and needed a coat in November.
-She thought it was important to see Resident #2's room, her clothes, and her bed because of her concerns.

Telephone interview with Resident #2's Power of Attorney (POA) on 04/30/24 at 4:42pm revealed:
-Visitation at the facility remained restricted after the COVID-19 pandemic.
-She flew in from out of state to visit Resident #2 and was told it was state law that she could not visit Resident #2 in her room.
-She had to sit in a room in the front of the facility after flying in from another state.

Interview with the Memory Care Director (MCD) on 05/01/24 at 3:51pm revealed Resident #2 might have been brought to the foyer in the front of the facility to visit with a family member because the resident's roommate was sleeping or bathing.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 5:33pm revealed:
-There were no visitors permitted in resident rooms that were shared with a roommate.
-Resident #2 had a roommate so staff brought her out to the foyer in the front of the facility for visits with family members.
-Visiting in the common areas on the SCU was not permitted because it was disruptive to other residents.
-Resident #2's HCPOA usually visited after 6:00pm when residents were getting ready for bed.

Interview with the Administrator on 05/02/24 at 2:53pm revealed:

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-She met Resident #2's POA once and did not remember any concerns with the visit.
-Resident #2's HCPOA did not visit often and usually preferred waiting in the foyer area for the resident to be brought out from the SCU.
-Resident #2 liked to visit with family in the foyer area because she liked the fireplace.
-There was one incident involving Resident #2's family member arriving late on the SCU and talking loud and rude to staff which caused a disturbance to staff and residents.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the Administrator on 05/02/24 at 2:53pm.

2. Review of Resident #4's current FL2 dated 04/24/24 revealed diagnoses included dementia, depression, hypertension, dyslipidemia, and diabetes.

Interview with Resident #4's family member on 05/02/24 at 9:59am revealed:
-When she visited Resident #4, she waited at the front entrance and staff members would bring Resident #4 to the sitting area near the front entrance.
-She was told that since Resident #4 had a roommate, she could not have visitors in her room in the Special Care Unit (SCU).
-The staff had brought Resident #4 out of the SCU for all visits for at least a year.
-She would like to go to Resident #4's room occasionally to see if she needed new clothing or shoes.

Interview with a medication aide (MA) on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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05/02/24 at 5:40pm revealed:
-She started working at the facility in November 2022.
-She normally worked the second shift, which was from 3:00pm-11:00pm.
-The facility's resident visiting hours ended at 7:00pm nightly.
-If a resident had a private room, the resident's family and visitors could visit the resident in their room on the SCU.
-If a resident had a semi-private room and had visitors, the staff took the resident out of the SCU and brought them to the common area at the front entrance to sit with their visitors.
-The staff was not allowed to bring a residents' family or visitors to their room in the SCU if they had a semi-private room because it could disturb their roommate.
-Since she started working at the facility, she had always taken residents that did not have a private room out of the SCU to visit with their families.
-She thought the reason why the facility implemented this policy for SCU residents was due to COVID-19, but she was not sure.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with the Administrator on 05/02/24 at 2:53pm.

_____

Interview with the Administrator on 05/02/24 at 2:53pm revealed:
-Visiting hours were between 9:00am and 7:00pm daily.
-SCU residents were brought to the front foyer area for visits out of respect and consideration for their roommate if their roommate was sleeping.
-Residents on the SCU with private rooms were

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D 338	Continued From page 26 able to have visitors in their rooms. -She did not know a family member was told it was the facility's policy not to visit on the SCU. -She thought that might have happened during the COVID-19 pandemic. -Family members were able to visit on the SCU in resident rooms when it did not interfere with any roommates. -It was not a policy to restrict family members from visiting residents on the SCU.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#1) for finger stick blood sugar checks (FSBS) and blood pressure checks (BP). The findings are: Review of Resident #1's current FL-2 dated	D 344		

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D 344	Continued From page 27 01/09/24 revealed diagnoses included stage 4 chronic kidney disease (CKD), trans ischemic attach (TIA), venous insufficiency and type 2 diabetes mellitus with complications. a. Review of a handwritten physician's order dated 03/11/24 for Resident #1 revealed there was an order stating the patient can check her own blood sugar once daily in the morning or every night at bedtime (qhs). Patient can alter timing. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for finger stick blood sugars (FSBS) to be done daily, 1 time every week, Monday, Wednesday and Friday. -The FSBS were checked on Monday, Wednesday and Friday on 03/13/24, 03/15/24, 03/18/24, 03/20/24, 03/22/24, 03/25/24, 03/27/24 and 03/29/24. Review of Resident #1's April 2024 MAR revealed: -There was an entry for FSBS to be done daily, 1 time every week, Monday, Wednesday and Friday. -The FSBS were checked Monday, Wednesday and Friday on 04/01/24, 04/03/24, 04/15/24, 04/17/24, 04/19/24, 04/26/24, and 04/29/24. -There was an entry at 8:00pm on 04/04/24 to 04/11/24 and 8:00am on 04/05/24 to 04/12/24 of Resident #1 being out of the facility. Review of the facility's electronic vital signs report for Resident #1 revealed FSBSs were taken Monday, Wednesday and Friday on 03/13/24, 03/15/24, 03/18/24, 03/20/24, 03/25/24, 03/27/24, 03/29/24, 04/01/24, 04/03/24, 04/15/24, 04/17/24,	D 344		

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D 344	Continued From page 28 04/19/24, 04/26/24, 04/29/24, and 05/01/24. Interview with Resident #1 on 05/02/24 at 10:35am revealed: -She did not check her own FSBS anymore. -She had not taken her own FSBS in about a month -Staff checked her FSBS every morning. -She had not had any FSBS issues that she was aware of. Interviews with a medication aide (MA) on 05/02/24 at 11:30am and 2:45pm revealed: -Resident #1 did not take her own FSBS. -Resident #1's FSBS was taken once per week on Wednesday. -Resident #1's FSBS was taken daily when she first arrived at the facility but the order was changed to Monday, Wednesday and Friday. -She knew when to check Resident #1's FSBS because a notification to check the FSBS popped up on the computer Monday, Wednesday and Friday. Interview with a second MA on 05/02/24 at 5:45pm revealed: -If there were questions or issues with any orders, they were supposed to contact the HWD. -There was a book that contained the orders for the FSBS so if there was confusion, they were supposed to refer to the book. -The MAR and the BS order book were supposed to match. -If there were continued clarification issues the Health and Wellness Director (HWD) was to be contacted. Interview with Resident #1's primary care provider (PCP) on 05/02/24 at 6:35pm revealed: -The FSBS order did not sound familiar to her.	D 344		

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-Resident #1 had never taken her own FSBS since she had been at the facility that she was aware of.

Attempted interview with the RCC on 05/02/24 was unsuccessful.

b. Review of Resident #1's current FL-2 dated 01/09/24 revealed there was an order for blood pressure (BP) checks once a day, as needed.

Review of a handwritten physician's order dated 03/11/24 for Resident #1 revealed there was an order to check blood pressure (BP) every Monday, Wednesday and Friday, once on these days.

Review of the facility's handwritten monthly vital sign and weight flow sheet for March 2024 revealed Resident #1's BP was taken 03/04/24.

Review of the facility's handwritten monthly vital sign and weight flow sheet for April 2024 revealed:
-There was no date on the form other than the month and year.
-Resident #1 had a blank space by her name for vital signs.

Review of the facility's electronic vital signs report revealed Resident #1's BP was taken 03/05/24, 04/12/24, 04/13/24, 04/14/24, 04/16/24 and 05/02/24.

Interviews with a medication aide (MA) on 05/02/24 at 11:30am and 2:45pm revealed she would not know when to check Resident #1's BP because the order said daily, as needed.

Interview with the primary care provider (PCP) on

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D 344	Continued From page 30 05/02/24 at 6:35pm revealed: -She wanted the BP checked weekly, not three times a week as that would be overdoing it. -She had no concerns regarding the missed BP checks. Attempted interview with the RCC on 05/02/24 was unsuccessful. Refer to interview with the HWD on 05/02/24 at 12:10pm. Refer to interview with the Administrator on 05/02/24 at 2:45pm. _____ Interview with the Health and Wellness Director (HWD) on 05/02/24 at 12:10pm revealed: -The Resident Care Coordinator (RCC) was responsible for verifying and clarifying the electronic medication administration record(eMAR) and orders. -She did not know how staff knew when to check Resident #1's finger stick blood sugar (FSBS) or blood pressure (BP). Interview with the Administrator on 05/02/24 at 2:45pm revealed: -She was not aware of Resident #1's BP and FSBS orders. -When orders were received, the medication aide ((MA) sent the orders to the pharmacy. -The pharmacy added the orders to the eMAR. -The HWD and RCC were responsible for clarifying and approving the orders. -The orders for Resident #1's BP and FSBS were confusing so she was unsure how the MA would know when to check the BP and FSBS. -She was unsure why the eMAR was not updated with the 03/11/24 order.	D 344		

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D 350	10A NCAC 13F .1002 (g) Medication Orders 10A NCAC 13F .1002 Medication Orders (g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that controlled substances ordered as needed had detailed behavior-specific indications for use for 2 of 5 sampled residents (#2, #4). The findings are: 1. Review of Resident #4's current FL2 dated 04/24/24 revealed: -Diagnoses included dementia, depression, hypertension, hyperlipidemia, diabetes, and chronic osteoarthritis. -There was an order for Lorazepam 0.5mg, 1 tablet every 6 hours PRN (PRN is an abbreviation meaning as needed) (Lorazepam is a medication used to treat anxiety or agitation).	D 350		

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D 350	Continued From page 32 Review of Resident #4's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg, take 1 tablet every 6 hours as needed. -There was no indication for use on Resident #4's Lorazepam eMAR entry. -Lorazepam 0.5mg was documented as administered on 03/10/24 at 5:30pm and on 03/21/24 at 8:30pm. Review of Resident #4's April 2024 eMAR revealed: -There was an entry for Lorazepam 0.5mg, take 1 tablet every 6 hours as needed. -There was no indication for use on Resident #4's Lorazepam eMAR entry. -Lorazepam 0.5mg was documented as administered on 04/08/24 at 5:27pm, 04/10/24 at 7:32pm, 04/14/24 at 1:04pm, and 04/20/24 at 5:30pm. Review of Resident #4's May 2024 eMAR revealed: -There was an entry for Lorazepam 0.5mg, take 1 tablet every 6 hours as needed. -There was no indication for use on Resident #4's Lorazepam eMAR entry. -There were no administered doses documented for May 2024. Interview with a medication aide (MA) on 05/02/24 at 5:40pm revealed: -She administered Lorazepam 0.5mg to Resident #4 as needed for agitation. -The MAR and medication label on Resident #4's Lorazepam did not have a reason to administer the medication. -She knew Lorazepam was for anxiety and	D 350		

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agitation, so she administered it if she observed Resident #4 having those symptoms.

Interview with the Memory Care Director (MCD) on 05/02/24 at 12:21pm revealed:
-All medications that were ordered as needed should have a reason on the MAR to administer the medication.
-If the order did not have a reason to give the medication, the order should be clarified by the provider.
-She was unsure why Resident #4's Lorazepam did not have an indication for use.
-An indication for use was important so the staff would know why to administer Resident #4's Lorazepam.

Interview with the Health and Wellness Director on 05/02/24 at 4:17pm revealed:
-She and the Resident Care Coordinator (RCC) checked all orders on the eMAR weekly for accuracy.
-Medications scheduled as needed should have an indication for use.
-She was unsure why Resident #4's Lorazepam did not have an indication for use.
-She thought the staff knew what Lorazepam was used for and would know when to administer it to Resident #4.

Interview with the Administrator on 05/02/24 at 2:52am revealed:
-The RCC and HWD checked the eMARs and medication carts weekly for accuracy.
-Medications ordered as needed should have an indication for use.
-The indication for use helped the MAs to know the reason to give a medication.
-She was unsure why Resident #4's Lorazepam did not have a reason to administer.

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D 350	Continued From page 34 Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #2's current FL-2 dated 04/24/24 revealed: -Diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety. -There was an order for lorazepam 0.5mg every 8 hours as needed. -There was no documentation of the administration reason and parameters. Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMARs) revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed. -There was documentation one dose of lorazepam 0.5mg was administered on 03/29/24 at 12:59pm. -There was documentation lorazepam 0.5mg administered on 03/29/24 was effective. Observation of Resident #2's medications on hand revealed: -There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for lorazepam 0.5mg every 8 hours as needed. -The pharmacy label indicated 30 lorazepam 0.5mg tablets were dispensed on 02/02/24 and 28 tablets remained. -There was no reason specified to administer on the pharmacy label. Review of Resident #2's primary care provider (PCP) visit note dated 02/02/24 revealed: -Resident #2 was seen for a telehealth visit for	D 350		

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anxiety review and medication refill.
-The plan included lorazepam 0.5mg every 8 hours as needed.
-There was no documentation of the administration reason and parameters.

Interview with a medication aide (MA) on 05/02/24 at 12:34pm revealed:
-She documented administering lorazepam to Resident #2 on 03/29/24 at 12:59pm.
-She administered lorazepam because Resident #2 was trying to walk around unassisted, and she was unsteady on her feet.
-Resident #2 was all over the place and she was worried the resident might fall.
-She knew the lorazepam was effective because she sat with Resident #2 and the resident calmed down.
-The Resident Care Coordinator (RCC) told her lorazepam was administered for behaviors.

Interview with the Memory Care Director (MCD) on 05/01/24 at 3:51pm revealed the Health and Wellness Director (HWD) was responsible for clinical related matters including medications and medication orders.

Telephone interview with Resident #2's PCP on 05/02/24 at 11:37pm revealed:
-As needed medications should have a reason so that staff knew when to administer the medication.
-She thought the prescription order she wrote for Resident #2's lorazepam included anxiety as the reason.

Upon request on 04/30/24, 05/01/24, and 05/02/24, Resident #2's prescription order for lorazepam was not provided for review.

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D 350	Continued From page 36 Interview with the HWD on 05/02/24 at 5:33pm revealed: -MAs were responsible to immediately report incomplete medication to the MCD. -The MCD brought the order concern to her or the PCP. Interview with the Administrator on 05/02/24 at 2:53pm revealed: -As needed medication orders should indicate the reason to administer. -MAs needed to know why they were administering as needed medications and what determined effectiveness. -The HWD was responsible for reviewing medication orders. -MAs were responsible for asking the PCP to clarify the reason for administration of as needed medications. -Resident #2's as needed lorazepam should have had a reason to administer clarified by the PCP. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted interview with the Resident Care Coordinator (RCC) on 05/02/24 at 1:25pm was unsuccessful.	D 350		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#6) with errors observed during the medication pass including medication used to treat pulmonary disease and medication used to treat constipation and for 3 of 5 residents (#1, #2, #4) sampled for record review related to the administration of a medication used to lower cholesterol (#4), medication used to treat pulmonary disease (#1), and medication used to treat Alzheimer's disease, medication used to seasonal allergies, medication used to prevent and treat constipation, medication used to treat acid reflux, medication used to treat depression and insomnia, and medication used to treat vitamin deficiency (#2).

The findings are:

Review of the facility's Medication Policy dated 12/19/23 revealed it was the policy of the facility to supervise and administer all medications that the residents received as ordered by the physician unless they had orders to self-administer medications.

The medication error rate was 6% as evidenced by 2 errors out of 31 opportunities during the 8:00am medication pass on 05/01/24.

1. Review of Resident #6's current FL2 dated 04/13/24 revealed diagnoses included acute urinary tract infection, pulmonary emphysema, gastroesophageal reflux disease, and hypertension.

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a. Review of Resident #6's discharge summary dated 04/13/24 revealed an order for Advair Diskus 250-50mcg, inhale one puff in the morning and 1 puff before bedtime (Advair Diskus is an inhaled medication used to treat pulmonary disease).

Observation of the 8:00am assisted living (AL) medication pass on 05/01/24 from 7:18am to 7:34am revealed:
-The medication aide (MA) prepared Resident #6's medications, which included 5 tablets, a medication dissolved in water, and a nasal spray.
-The MA administered Resident #6's medications at 7:23am.
-Advair Diskus 250-50mcg was not administered to Resident #6 during the observation.

Review of Resident #6's May 2024 electronic medication administration record (eMAR) revealed there was no entry for Advair Diskus 250-50 mcg, inhale one puff in the morning and 1 puff before bedtime.

Interview with Resident #6 on 05/01/24 at 11:25am revealed:
-She used to use inhalers but had not used any inhalers in a while.
-She was unsure of the last time she used an inhaler.
-She was unsure if she had used Advair since she moved into the facility.
-She was not having any episodes of shortness of breath or wheezing.

Interview with the MA on 05/01/24 at 12:30pm revealed:
-The Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) were responsible

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for reviewing the residents' orders when returning from the hospital.
-Resident #6 had orders for some inhalers, but those orders were discontinued.
-She was unsure of the names of the inhalers that were discontinued.
-She was not aware of Resident #6's current order for Advair 250-50mcg.

Interview with the Health and Wellness Director on 05/01/24 at 12:57am revealed:
-When a resident returned from the hospital either she or the RCC reviewed their discharge paperwork and orders.
-She was unsure why Resident #6's Advair Diskus 250-50mcg order was on the discharge medication list from the hospital.
-The MA that sent Resident #6 to the hospital could have sent an incorrect medication list when Resident #6 was sent to the emergency room.
-She did not review Resident #6's medication orders when she returned from the hospital.

Interview with the Administrator on 05/01/24 at 1:10pm revealed:
-If there was a current order for a medication, the medication should be available to be administered.
-The RCC or HWD were responsible for reviewing medication orders for accuracy.

Telephone interview with primary care provider (PCP) on 05/01/24 at 11:41am revealed Resident #6 was not having any shortness of breath or wheezing, so she may no longer need Advair Diskus 250-50mcg.

b. Review of Resident #6's discharge summary dated 04/13/24 revealed there was an order for Miralax, take 17gm in the morning (Miralax is a

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medication used to treat and prevent constipation).

Observation of the 8:00am assisted living (AL) medication pass on 05/01/24 from 7:18am to 7:34am revealed:
-The medication aide (MA) prepared Resident #6's medications, which included 5 tablets, Miralax 17gm dissolved in water, and a nasal spray.
-At 7:23am, the MA entered the living room where Resident #6 was sitting.
-The MA gave Resident #6 a medicine cup containing tablets and the cup of Miralax.
-Resident #6 put the tablets in her mouth and took a sip of Miralax.
-The MA administered Resident #6's nasal spray.
-The MA left the living room at 7:25am and Resident #6 had over 3/4 of a cup of Miralax remaining.

Observation of the living room on 05/01/24 at 7:34am revealed Resident #6 was in the living room with three other residents and there was no cup observed in her hand or in the living room.

Review of Resident #6's May 2024 electronic medication administration record revealed:
-There was an entry for Miralax, mix 17gm in 6-8 ounces of liquid and drink for constipation.
-Miralax 17 gm was documented as administered at 8:00am on 05/01/24.

Interview with Resident #6 on 05/01/24 at 11:25am revealed:
-She took Miralax for constipation every day and felt the medication was effective.
-The MAs gave her Miralax every morning and instructed her to drink it.
-She always drank the Miralax but none of the

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MAs stayed with her while she drank it.

Interview with the MA on 05/01/24 at 12:30pm revealed:
-She usually gave Resident #6 her Miralax and went back in about five minutes to see if she had finished all the medicine.
-She did not stay with Resident #6 while she drank Miralax each day.
-She checked this morning, 05/01/24, to see if Resident #6 finished drinking the Miralax and Resident #6 drank all the medication.
-She should have stayed with Resident #6 to be sure that she drank all the Miralax.

Interview with the Health and Wellness Director (HWD) on 05/01/24 at 12:57pm revealed:
-MAs should stay with residents and observe residents taking their medications.
-The MA should have stayed with Resident #6 to be sure the Miralax was taken.

Interview with the Administrator on 05/01/24 at 1:10pm revealed:
-MAs should stay with each resident during medication administration to be sure that the medications were taken.
-The MA could not be sure that Resident #6 drank all the Miralax if she did not stay with her until she was finished.

2. Review of Resident #4's current FL2 dated 04/24/24 revealed:
-Diagnoses included dementia, depression, hypertension, dyslipidemia, and diabetes.
-There was an order for Atorvastatin 20mg one tablet at bedtime (Atorvastatin is a medication used to lower cholesterol).

Review of Resident #4's March 2024 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 20mg, take one tablet at bedtime scheduled for 9:00am.
-Atorvastatin 20mg was documented as administered at 9:00am from 03/01/24 to 03/31/24.

Review of Resident #4's April 2024 eMAR revealed:
-There was an entry for Atorvastatin 20mg, take one tablet at bedtime scheduled for 9:00am.
-Atorvastatin 20mg was documented as administered at 9:00am from 04/01/24 to 04/30/24.

Review of Resident #4's May 2024 eMAR revealed:
-There was an entry for Atorvastatin 20mg, take one tablet at bedtime scheduled for 9:00am.
-Atorvastatin 20mg was documented as administered at 9:00am from 05/01/24 to 05/02/24.

Interview with a medication aide on 05/02/24 at 12:10pm revealed:
-She read the eMAR when administering medications so she would know the right medications to administer.
-She followed the instructions on the eMAR and matched the medication on the eMAR to the label.
-She had not noticed the instructions for Resident #4's Atorvastatin 20mg said to give at bedtime.
-She had been administering the medication at 9:00am because that was the time the medication was scheduled on the eMAR.
-If she had concerns or questions about medication orders, she notified the Health and Wellness Director (HWD).

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D 358	Continued From page 43 Interview with the Memory Care Director (MCD) on 05/02/24 at 12:21pm revealed: -MAs should be reading the eMAR and following the instructions on the eMAR. -The medication carts and eMARs were audited weekly by the MAs, Resident Care Coordinator (RCC), and HWD. -Medications should be scheduled for the time ordered by the residents' provider. -She did not participate in the cart and eMAR audits for the facility. Interview with the HWD on 05/02/24 at 4:17pm revealed: -The RCC entered new medications on the eMARs. -Either the MAs, RCC, or HWD checked the entries for accuracy. -The RCC and HWD reviewed all entries on the eMAR for each resident weekly. -She had not noticed Resident #4's Atorvastatin 20mg was scheduled for 9:00am instead of at bedtime. -She was unsure why Resident #4's Atorvastatin 20mg was scheduled for 9:00am. Interview with the Administrator on 05/02/24 at 2:52pm revealed: -The HWD was responsible for reviewing medication orders for accuracy. -The MAs should read the eMAR and follow the directions for administering the medications. -If Resident #4's Atorvastatin 20mg was ordered for bedtime, it should be administered at bedtime instead of 9:00am. Interview with Resident #4's primary care provider (PCP) on 05/02/24 at 12:00pm revealed: -Sometimes Atorvastatin 20mg was scheduled in	D 358		

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the evening for better absorption.
-Resident #4 could take Atorvastatin 20mg in the morning or evening.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

3. Review of Resident #1's current FL-2 dated 01/09/24 revealed diagnoses included stage 4 chronic kidney disease (CKD), trans ischemic attack (TIA) and diabetes mellitus with complications.

Review of a cardiology report dated 04/25/24 revealed Resident #1's cadiovascular problem list included chronic hypoxic respiratory failure secondary to small airway disease.

Review of Resident #1's most recent physician's orders dated 11/08/23 revealed an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL, inhale 1 vial via nebulizer twice daily. (Formoterol Fumarate Inhalation Solution is used to treat pulmonary disease.)

Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed:
-There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day scheduled for 8:00am and 8:00pm.
-Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am and 8:00pm from 03/01/24 to 03/31/24.

Review of Resident #1's April 2024 eMAR revealed:
-There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day

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scheduled for 8:00am and 8:00pm.
-Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am from 04/01/24 to 04/05/24 and 04/13/24 to 04/30/24 and 8:00pm from 04/01/24 to 04/03/24 and 04/12/24 to 04/29/24.
-There was an entry at 8:00pm on 04/04/24 to 04/11/24 and 8:00am on 04/05/24 to 04/12/24 of Resident #1 being out of the facility.

Review of Resident #1's May 2024 eMAR revealed:
There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day scheduled for 8:00am and 8:00pm.
-Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am on 05/01/24 and 8:00pm on 05/02/24.

Observation of Resident #1's medication on hand on 05/02/24 at 11:30am revealed there was no Formoterol Fumarate Inhalation Solution on the cart.

Observations of Resident #1's room on 05/02/24 at 12:00pm revealed:
-There were 7 packs of Formoterol Fumarate Inhalation Solution in her refrigerator in a bowl with a date of 11/2024 on the back of each pack.
-There was a nebulizer machine on the floor in between Resident #1's recliner and a shelf.

Interviews with a medication aide (MA) on 05/02/24 at 11:30am and 12:00pm revealed:
-The MA was responsible for administering medication.
-The MA was responsible for cart audits on Thursdays.
-The last cart audit was done last Thursday, 04/25/24.

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D 358	Continued From page 46 -The Formoterol Fumarate Inhalation Solution might be in Resident #1's room. -She did not know if Resident #1 had a self-administer order for Formoterol Fumarate Inhalation Solution. -She did not administer Resident #1's Formoterol Fumarate Inhalation Solution on 04/30/24, 05/01/24 and 05/02/24. -She marked the Formoterol Fumarate Inhalation Solution as administered on 04/30/24, 05/01/24 and 05/02/24 because Resident #1 told her she had already administered the medication herself. Interview with Resident #1 on 05/02/24 at 12:00pm and 3:40pm revealed: -She had Formoterol Fumarate Inhalation Solution in her refrigerator. -She was supposed to "use" the Formoterol Fumarate Inhalation Solution but did not. -She did not know how to administer the Formoterol Fumarate Inhalation Solution. -No one had been administering the Formoterol Fumarate Inhalation Solution to her. -She was supposed to receive Formoterol Fumarate Inhalation Solution in the morning and at night. -A MA brought the Formoterol Fumarate Inhalation Solution to her a couple of weeks ago and left it with her. -No one mentioned the Formoterol Fumarate Inhalation Solution to her when they administered her medications. -She did not mention the Formoterol Fumarate Inhalation Solution to anyone because "they should know." -The last time the Formoterol Fumarate Inhalation Solution was administered to her was about 2 weeks ago. -She had not had any issues as a result of not being administered the Formoterol Fumarate	D 358		

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Inhalation Solution but she felt better when she received the medication.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 12:10pm revealed:
-She was not aware Resident #1 had Formoterol Fumarate Inhalation Solution in her room.
-Resident #1 was not supposed to have Formoterol Fumarate Inhalation Solution in her room.
-The MA was responsible for administering medication.
-Resident #1 did not have a self-administer order for Formoterol Fumarate Inhalation Solution.
-The MA was supposed to order the medication if it was not on the cart.
-The MA was to notify her when it was time for a prescription for a refill.
-Cart audits were done by the MA once per week and the sheet was given to her and the Resident Care Coordinator (RCC).
-The last cart audit was done last Thursday, 04/25/24 and there was no notification of any medication being in Resident #1's room.

Interview with the Administrator on 05/02/24 at 2:45pm revealed:
-She did not know why the Formoterol Fumarate Inhalation Solution was marked on the eMAR as administered unless the MA administered the medication and allowed Resident #1 to keep the medication, which should not happen because the medication should be stored on the cart.
-Cart audits performed by the RCC and HWD should have discovered that the Formoterol Fumarate Inhalation Solution was not on the cart.
-Cart audits were done on a weekly basis but she did not know when the last cart audit was done.
-She did not see the results of the cart audits.
-If a medication was not on the cart, the MA

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should have made a request to the pharmacy and informed the HWD.
-The expectation was that the MA would administer all medications as ordered.

Interview with the primary care provider (PCP) on 05/02/24 at 6:35pm revealed:
-Facility staff usually reported to her if medications were not in the building
-She expected to be informed of any medication that had not been administered.
-She had no concerns about Resident #1 not receiving the Formoterol Fumarate Inhalation Solution if there were no issues and no issues had been reported to her.

Attempted interview with the RCC on 05/02/24 at 1:25pm was unsucessful.

Attempted telephone interview with the facility's contracted pharmacy on 05/02/24 at 5:54pm was unsuccessful.

4. Review of Resident #2's current FL-2 dated 04/24/24 revealed diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety.

a. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for fluticasone 50mcg 1 spray each nostril daily. (Fluticasone is used to treat nasal allergy symptoms.)

Review of Resident #2's emergency room (ER) discharge paperwork dated 03/28/24 revealed:
-Resident #2 was seen for a fall and diagnosis included closed fracture of the nasal bones.
-There were instructions to pick up medications with the printed prescription and start taking fluticasone.

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-The instructions did not specify the dosage or frequency of fluticasone.

Review of Resident #2's March and April 2024 electronic medication administration records (eMAR) revealed:
-There was no entry for fluticasone on Resident #2's March 2024 eMAR.
-There was an entry on Resident #2's April 2024 eMAR for fluticasone 50mcg 1 spray into nose daily at 8:00am with a start date of 04/01/24.
-The documentation box for 04/01/24 was shaded with no staff initials or abbreviation.
-There was documentation fluticasone was administered daily at 8:00am from 04/02/24 through 04/30/24.

Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed:
-There was a pharmacy brand box of fluticasone 50mcg spray with Resident #2's name and 04/03/24 handwritten on the box.
-There was a near full bottle of fluticasone inside the box.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy did not have an active order for fluticasone for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 05/01/24 at 1:16pm revealed:
-Fluticasone was used for nasal congestion.
-If fluticasone was on Resident #2's eMAR then she must have written an order.
-All orders, including orders from the hospital, went through her first for approval.
-She would understand doses that were not

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administered for a resident with dementia who might have been confused and in pain.
-Resident #2 might not have understood how to take nasal sprays.
-The date she signed the order was the expected start date of the medication.
-She did not know of any delay in starting the nasals spray following Resident #2's return to the facility from the hospital.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 5:33pm revealed:
-She thought the fluticasone was originally ordered when Resident #2 fell and had a nasal fracture (03/28/24).
-She was not sure because she never saw the ER discharge paperwork.
-The Resident Care Coordinator (RCC) documented receiving the ER discharge paperwork from the family member and must have processed the orders.

Attempted interview with the Resident Care Coordinator (RCC) on 05/02/24 at 1:25pm was unsuccessful.

b. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for Clearlax 17gm daily. (Clearlax is used to treat constipation.)

Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed:
-There was an entry for Clearlax 17gm daily at 9:00am with a start date of 03/28/23.
-There was documentation Clearlax was administered daily at 9:00am from 02/01/24 through 04/30/24.

Observation of Resident #2's medications on

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hand on 05/01/24 at 3:23pm revealed:
-There was an approximately half full manufacturer's bottle of Clearlax with a pharmacy label which had Resident #2's name and instructions for 17gms daily.
-The pharmacy label indicated the bottle was dispensed on 08/15/23.
-There was a faint handwritten open date of 10/ /23 on the side of the bottle.
-The day of the date was illegible.

Interview with the Memory Care Director (MCD) on 05/01/24 at 3:40pm revealed Clearlax did not come with cycle fills every month; refills had to be requested from the pharmacy.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed:
-The pharmacy had an order for Clearlax 17gm daily dated 03/02/23 and dispensed 1 bottle which was a 30-day supply on 08/15/23 for Resident #2.
-Clearlax was not a cycle fill medication and needed to be requested.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 5:33pm revealed:
-Resident #2's Clearlax dispensed on 08/15/23 should have been used and gone.
-Resident #2 did not currently have any problems with diarrhea or constipation.

Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed:
-The facility's contracted pharmacy changed, and she had to refill orders for every resident.
-She thought that could have been the reason Resident #2 had extra medications on hand.

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D 358	Continued From page 52 -She did not know of Resident #2 experiencing any symptoms of potentially missed doses of medications. -Resident #2 took Clearlax for constipation. c. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for vitamin D3 50mcg 2 tablets daily. (Vitamin D3 is used to treat vitamin D deficiency.) Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed: -There was an entry for vitamin D3 50mcg 2 tablets daily at 9:00am with a start date of 03/27/23. -There was documentation vitamin D3 was administered daily at 9:00am from 02/01/24 through 04/30/24. Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed: -There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for vitamin D3 50mcg 2 tablets daily. -The pharmacy label indicated 60 tablets were dispensed on 11/19/23 and 60 tablets remained (single tablet per bubble). -There was a second bubble pack with a pharmacy label which had Resident #2's name and instructions for vitamin D3 50mcg 2 tablets daily. -The pharmacy label indicated 60 tablets were dispensed on 01/18/24 and 30 tablets remained (single tablet per bubble). -There was a third bubble pack with a pharmacy label which had Resident #2's name and instructions for vitamin D3 50mcg 2 tablets daily. -The pharmacy label indicated 60 tablets were dispensed on 02/14/24 and 60 tablets remained	D 358		

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(single tablet per bubble).
-There was a fourth bubble pack with a pharmacy label which had Resident #2's name and instructions for vitamin D3 50mcg 2 tablets daily.
-The pharmacy label indicated 60 tablets were dispensed on 03/14/24 and 60 tablets remained (single tablet per bubble).
-There was a fifth bubble pack with a pharmacy label which had Resident #2's name and instructions for vitamin D3 50mcg 2 tablets daily.
-The pharmacy label indicated 56 tablets were dispensed on 04/19/24 and 56 tablets remained (single tablet per bubble).

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy had an order for vitamin D3 50mcg 2 tablets daily dated 03/02/23 and had dispensed 60 tablets which was a 30-day supply on 02/14/24, 03/14/24 and 04/19/24 for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed Resident #2 took vitamin D3 as a replacement.

d. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for donepezil 10mg daily at bedtime. (Donepezil is used to treat dementia.)

Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed:
-There was an entry for donepezil 10mg daily at bedtime scheduled for 9:00pm with a start date of 03/28/23.
-There was documentation donepezil was administered daily at 9:00pm from 02/01/24

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D 358	Continued From page 54 through 04/29/24. Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed: -There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for donepezil 10mg daily at bedtime. -The pharmacy label indicated 30 tablets were dispensed on 03/14/24 and there were 8 remaining. -There was a second bubble pack with a pharmacy label which had Resident #2's name and instructions for donepezil 10mg daily at bedtime. -The pharmacy label indicated 28 tablets were dispensed on 04/19/24 and there were 28 remaining. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy's current order for donepezil 10mg daily was dated 04/03/24 and had dispensed 30 tablets which was a 30-day supply on 02/14/24, 03/14/24 and 04/19/24 for Resident #2. Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed Resident #2 took donepezil for dementia. e. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for mirtazapine 15mg daily at bedtime. (Mirtazapine is used to treat depression and insomnia.) Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed: -There was an entry for mirtazapine 15mg daily at	D 358		

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bedtime scheduled for 9:00pm with a start date of 03/28/23.
-There was documentation mirtazapine was administered daily at 9:00pm from 02/01/24 through 04/29/24.

Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed:
-There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for mirtazapine 15mg daily at bedtime.
-The pharmacy label indicated 30 tablets were dispensed on 03/14/24 and there were 4 remaining.
-There was a second bubble pack with a pharmacy label which had Resident #2's name and instructions for mirtazapine 15mg daily at bedtime.
-The pharmacy label indicated 28 tablets were dispensed on 04/19/24 and there were 28 remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy had an order for mirtazapine 15mg daily dated 03/02/23 and had dispensed 30 tablets which was a 30-day supply on 02/14/24, 03/14/24 and 04/19/24 for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed Resident #2 took mirtazapine for leg cramps.

f. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for trazadone 50mg daily at bedtime. (Trazadone is used to treat depression.)

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Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed:
-There was an entry for trazadone 50mg daily at bedtime scheduled for 9:00pm with a start date of 05/02/23.
-There was documentation trazadone was administered daily at 9:00pm from 02/01/24 through 04/29/24.

Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed:
-There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for trazadone 50mg daily at bedtime.
-The pharmacy label indicated 30 tablets were dispensed on 03/14/24 and there were 8 remaining.
-There was a second bubble pack with a pharmacy label which had Resident #2's name and instructions for trazadone 50mg daily at bedtime.
-The pharmacy label indicated 30 tablets were dispensed on 04/11/24 and there were 30 remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy had an order for trazadone 50mg daily at bedtime dated 03/02/23 and had dispensed 30 tablets which was a 30-day supply on 02/14/24, 03/14/24 and 04/11/24 for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed Resident #2 took trazadone for insomnia.

g. Review of Resident #2's current FL-2 dated

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D 358	Continued From page 57 04/24/24 revealed an order for omeprazole 20mg daily. (Omeprazole is used to treat acid reflux.) Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed: -There was an entry for omeprazole 20mg daily at 6:00am with a start date of 09/15/23. -There was documentation omeprazole was administered daily at 6:00am from 02/01/24 through 04/30/24. Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed: -There was a bubble pack with a pharmacy label which had Resident #2's name and instructions for omeprazole 20mg daily. -The pharmacy label indicated 30 capsules were dispensed on 03/14/24 and there were 12 remaining. -There was a second bubble pack with a pharmacy label which had Resident #2's name and instructions for omeprazole 20mg daily. -The pharmacy label indicated 30 capsules were dispensed on 04/11/24 and there were 28 remaining. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy had an order for omeprazole 20mg daily dated 03/02/23 and had dispensed 30 capsules which was a 30-day supply on 02/14/24, 03/14/24 and 04/11/24 for Resident #2. Telephone interview with Resident #2's primary care provider (PCP) on 05/02/24 at 11:37pm revealed Resident #2 took omeprazole for reflux. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 58 05/01/24 at 3:23pm revealed: -Medications were automatically refilled every month with cycle fills. -MAs were responsible for removing old bubble packs when new bubble packs were put on the medication cart. -If Resident #2 was in the hospital for a day or two, medications would not have been administered and there would have been some extra. -Resident #2 was not in the hospital recently that she knew of. -She did not know why Resident #2 had so much medication on hand. Interview with a second MA on 05/02/24 at 2:35pm revealed: -She noticed there were a lot of medications on hand for Resident #2. -She thought medications might not always be administered to Resident #2. -Resident #2 liked to sleep. -She had to be patient with Resident #2 when she administered medications to her. -If she could not administer medication, she documented the medication was not administered and the reason. Interviews with the Memory Care Director (MCD) on 05/01/24 at 3:40pm and 3:51pm revealed: -MAs were responsible for completing medication cart audits every week on various shifts. -The Health and Wellness Director (HWD) was responsible for clinical related matters including medications and medication orders. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed: -The facility was on cycle fill every 30 days for	D 358		

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scheduled medications in pill form.
-Both staff and the pharmacy could enter orders on the eMAR.
-The pharmacy primarily entered orders during business hours and staff was able to enter orders after business hours.
-There were different April 2024 cycle fill dates for Resident #2's medications due to the possibility of those medications being out of refills and needing a new prescription order.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 5:33pm revealed:
-She did not know there was an accumulation of medications on hand for Resident #2.
-There should not have been extra medications on the medication cart for Resident #2.
-The MAs were responsible for returning overflow medications back to the pharmacy.
-Scheduled medications were cycle filled with a 30-day supply between the 20th and 25th of the month.
-New bubble packs were put on the medication cart the date they were supposed to start by the MA.
-Old bubble packs which should have been near empty were removed from the medication cart.

Interview with the Administrator on 05/02/24 at 2:53pm revealed:
-The facility was on cycle fills for scheduled medications.
-She did not know why old medications were still on the medication cart.
-The new or current cycle medications should have been on the medication cart.
-The old medications or previous cycle medications should have been returned to the pharmacy.
-MAs were responsible for administering

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D 358	Continued From page 60 medications as ordered and entered on the eMAR. -MAs were responsible for documenting any medications that were not administered and the reason on the eMAR. -The Health and Wellness Director (HWD) was responsible for completing medication cart audits. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367		

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Based on observations, interviews, and record reviews, the facility failed to ensure that electronic medication administration records (eMAR) were accurate for 2 of 5 sampled residents (#1 and #2) related to the administration of a medication for pulmonary disease (#1) and a nasal spray and laxative (#2).

The findings are:

Review of the facility's electronic medication administration records (eMAR) policy dated 06/30/23 revealed each eMAR should be accurate and up to date.

1. Review of Resident #1's current FL-2 dated 01/09/24 revealed diagnosis included stage 4 chronic kidney disease (CKD).

Review of Resident #1's most recent physician's order sheet dated 11/08/23 revealed an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL, inhale 1 vial via nebulizer twice daily. (Formoterol is used to treat pulmonary disease.)

Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed:
-There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day scheduled for 8:00am and 8:00pm.
-Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am and 8:00pm from 03/01/24 to 03/31/24.

Review of Resident #1's April 2024 eMAR revealed:
-There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day scheduled for 8:00am and 8:00pm.

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D 367	Continued From page 62 -Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am from 04/01/24 to 04/05/24 and 04/13/24 to 04/30/24 and 8:00pm from 04/01/24 to 04/03/24 and 04/12/24 to 04/29/24. -There was an entry at 8:00pm on 04/04/24 to 04/11/24 and 8:00am on 04/05/24 to 04/12/24 of Resident #1 being out of the facility. Review of Resident #1's May 2024 eMAR revealed: There was an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL twice a day scheduled for 8:00am and 8:00pm. -Formoterol Fumarate Inhalation Solution was documented as administered at 8:00am on 05/01/24 and 8:00pm on 05/02/24. Observation of Resident #1's medication on hand on 05/02/24 at 11:30am revealed there was no Formoterol Fumarate Inhalation Solution on the cart. Observation of medication in Resident #1's room on 05/02/24 at 12:00pm revealed: -There were 7 packs of Formoterol Fumarate Inhalation Solution in her refrigerator in a bowl with a date of 11/2024 on the back of each pack. -The nebulizer was on the floor in between Resident #1's recliner and a shelf. Interviews with a medication aide (MA) on 05/02/24 at 11:30am and 12:00pm revealed: -MAs were responsible for administering medication. -She did not administer Resident #1's Formoterol Fumarate Inhalation Solution on 04/30/24, 05/01/24 and 05/02/24. -She marked the Formoterol Fumarate Inhalation Solution as administered on 04/30/24, 05/01/24	D 367		

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and 05/02/24 because Resident #1 told her she had already administered the medication herself.

Interview with Resident #1 on 05/02/24 at 12:00pm and 3:40pm revealed:
-She was supposed to "use" the Formoterol Fumarate Inhalation Solution but did not.
-She did not know how to administer the Formoterol Fumarate Inhalation Solution.
-No one had been administering the Formoterol Fumarate Inhalation Solution to her.
-She was supposed to receive Formoterol Fumarate Inhalation Solution in the morning and at night.
-No one mentioned the Formoterol Fumarate Inhalation Solution to her when they administered her medications.
-She did not mention the Formoterol Fumarate Inhalation Solution to anyone because "they should know."
-The last time the Formoterol Fumarate Inhalation Solution was administered to her was about 2 weeks ago.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 12:10pm revealed:
-The MA was responsible for administering medication.
-She did not know Formoterol Fumarate Inhalation Solution had not been administered to Resident #1.
-She did not know why Formoterol Fumarate Inhalation Solution was documented as administered.

Interview with the Administrator on 05/02/24 at 2:45pm revealed:
-She was not aware Resident #1 had not been administered Formoterol Fumarate Inhalation Solution.

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THE ADDISON OF INDIAN TRAIL	5306 SECREST SHORT CUT ROAD MONROE, NC 28110

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D 367	Continued From page 64 -She did not know why the Formoterol Fumarate Inhalation Solution was marked on the eMAR as administered unless the MA administered the medication and allowed Resident #1 to keep the medication, which should not happen because the medication should be stored on the cart. Attempted interview with the Resident Care Coordinator (RCC) on 05/02/24 at 1:25pm was unsucessful. 2. Review of Resident #2's current FL-2 dated 04/24/24 revealed diagnoses included dementia, gastro-esophageal reflux disease, spondylosis, insomnia, and anxiety. a. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for fluticasone 50mcg 1 spray each nostril daily. (Fluticasone is used to treat nasal allergy symptoms.) Review of Resident #2's emergency room (ER) discharge paperwork dated 03/28/24 revealed: -Resident #2 was seen for a fall and diagnosis included closed fracture of the nasal bones. -There were instructions to pick up medications with the printed prescription and start taking fluticasone. -The instructions did not specify the dosage or frequency of fluticasone. Review of Resident #2's March and April 2024 electronic medication administration records (eMAR) revealed: -There was no entry for fluticasone on Resident #2's March 2024 eMAR. -There was an entry on Resident #2's April 2024 eMAR for fluticasone 50mcg 1 spray into nose daily at 8:00am with a start date of 04/01/24. -The documentation box for 04/01/24 was shaded	D 367		

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with no staff initials or abbreviation.
-There was documentation fluticasone was administered daily at 8:00am from 04/02/24 through 04/30/24.
-There was no documentation doses of fluticasone were not administered.

Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed:
-There was a pharmacy brand box of fluticasone 50mcg spray with Resident #2's name and 04/03/24 handwritten on the box.
-There was a near full bottle of fluticasone inside the box.

Attempted interview with the Resident Care Coordinator (RCC) on 05/02/24 at 1:25pm was unsuccessful.

b. Review of Resident #2's current FL-2 dated 04/24/24 revealed an order for Clearlax 17gm daily. (Clearlax is used to treat constipation.)

Review of Resident #2's February, March, and April 2024 electronic medication administration records (eMAR) revealed:
-There was an entry for Clearlax 17gm daily at 9:00am with a start date of 03/28/23.
-There was documentation Clearlax was administered daily at 9:00am from 02/01/24 through 04/30/24.
-There was no documentation doses of Clearlax were not administered.

Observation of Resident #2's medications on hand on 05/01/24 at 3:23pm revealed:
-There was an approximately half full manufacturer's bottle of Clearlax with a pharmacy label which had Resident #2's name and instructions for 17gms daily.

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-The pharmacy label indicated the bottle was dispensed on 08/15/23.
-There was a faint handwritten open date of 10/ /23 on the side of the bottle.
-The day of the date was illegible.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/02/24 at 10:28am revealed the pharmacy had an order for Clearlax 17gm daily dated 03/02/23 and dispensed 1 bottle which was a 30-day supply on 08/15/23 for Resident #2.

Interview with the Health and Wellness Director (HWD) on 05/02/24 at 5:33pm revealed Resident #2's Clearlax dispensed on 08/15/23 should have been used and gone.

Interview with a medication aide (MA on 05/02/24 at 2:35pm revealed:
-She noticed there were a lot of medications on hand for Resident #2.
-She thought medications might not always be administered to Resident #2.
-Resident #2 liked to sleep.
-She had to be patient with Resident #2 when she administered medications to her.
-If she could not administer medication, she documented the medication was not administered and the reason.

Interview with the Administrator on 05/02/24 at 2:53pm revealed:
-She did not know why old medications were still on the medication cart.
-MAs were responsible for administering medications as ordered and entered on the eMAR.
-MAs were responsible for documenting any medications that were not administered and the

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D 367	Continued From page 67 reason on the eMAR. -The Regional Nurse reviewed eMAR documentation. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 367		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored securely when a medication aide left a medication cart unlocked and unattended in the Special Care Unit (SCU) and the facility failed to ensure medications were stored securely on the medication cart for 1 of 5 sampled residents (#1). The findings are: 1.Review of the facility's medication storage policy dated 06/30/23 revealed centrally stored medications will be kept in a locked medicine cabinet or cart unless refrigeration is required. Observation of the 8:00am medication pass on the Special Care Unit (SCU) on 05/01/24 from 7:35am to 7:48am revealed:	D 378		

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D 378	Continued From page 68 -The medication aide (MA) prepared a resident's medications and walked away from the medication cart, leaving the cart unlocked at 7:39am. -The MA entered a sitting area and administered a resident's medication. -When the MA returned to the medication cart at 7:40am, the cart remained unlocked. -There were no residents observed near the unlocked medication cart. -The MA locked the medication cart at 7:40am. Interview with the MA on 05/01/24 at 7:48am revealed: -She normally locked the medication cart when she walked away from the cart. -She did not lock the medication cart today, 05/01/24, because she was focused on giving a resident his medications. -Residents could open the medication cart and take medications or other items if the medication cart was left unlocked. Interview with the Memory Care Director (MCD) on 05/01/24 at 11:19am revealed: -The medication cart should be locked when unattended. -MAs were responsible for all medications and items stored in the medication cart. -The residents could be harmed if they opened an unlocked medication cart and took something from the cart. Interview with the Health and Wellness Director on 05/01/24 at 11:36am revealed: -MAs should lock the medication cart when unattended. -Residents or other staff members could access medications on the cart if it was unlocked.	D 378		

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D 378	Continued From page 69 Interview with the Administrator on 05/01/24 at 1:10pm revealed: -MAs should lock the medication cart when not in use. -The MA should have ensured the cart was locked before going to administer a resident's medications. -Residents could be harmed if they took something out of the unlocked medication cart. -It was important for the MAs to be sure to lock all medication carts in the facility, especially in the SCU because the residents in SCU had dementia or could be confused. 2. Review of Resident #1's current FL-2 dated 01/09/24 revealed diagnoses included major stage 4 chronic kidney disease (CKD), trans ischemic attach (TIA), venous insufficiency and type 2 diabetes mellitus with complications. Review of Resident #1's most recent physician's order sheet dated 11/08/23 revealed an order for Formoterol Fumarate Inhalation Solution 20 mcg/2mL, inhale 1 vial via nebulizer twice daily. (Formoterol is used to treat pulmonary disease.) Observation of Resident #1's medication on hand on 05/02/24 at 11:30am revealed there was no Formoterol Fumarate Inhalation Solution on the cart. Observation of medication in Resident #1's room on 05/02/24 at 12:00pm revealed: -There were 7 packs of Formoterol Fumarate Inhalation Solution in her refrigerator in a bowl with a date of 11/2024 on the back of each pack. -The nebulizer was on the floor in between Resident #1's recliner and a shelf. Interview with Resident #1 on 05/02/24 at	D 378		

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D 378	Continued From page 70 12:00pm and 3:40pm revealed: -She had Formoterol Fumarate Inhalation Solution in her refrigerator in a bowl. -An MA brought the Formoterol Fumarate Inhalation Solution to her a couple of weeks ago and left it with her. Interviews with a medication aide (MA) on 05/02/24 at 11:30am and 12:00pm revealed: -The Formoterol Fumarate Inhalation Solution might be in Resident #1's room. -She did not know if Resident #1 had a self-administration order for Formoterol Fumarate Inhalation Solution. Interview with the Health and Wellness Director (HWD) on 05/02/24 at 12:10pm revealed: -She was not aware Resident #1 had Formoterol Fumarate Inhalation Solution in her room. -Resident #1 was not supposed to have Formoterol Fumarate Inhalation Solution in her room. -She had to remove medication from Resident #1's room in the past due to the resident purchasing her own medications. -She explained the medication storage policy to Resident #1 in the past. Interview with the Administrator on 05/02/24 at 2:45pm revealed: -Staff previously removed medication from Resident #1's room and explained the medication storage policy to Resident #1 and her responsible person. -She was not aware Resident #1 currently had Formoterol Fumarate Inhalation Solution in her room. -The Formoterol Fumarate Inhalation Solution should have been on the cart. -The Formoterol Fumarate Inhalation Solution	D 378		

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D 378	Continued From page 71 should not have been in Resident #1's room. Interview with the primary care provider (PCP) on 05/02/24 at 6:35pm revealed: -She did not feel having the Formoterol Fumarate Inhalation Solution in the room caused any harm to Resident #1. -She had no concerns if there were no issues and no issues had been reported to her.	D 378		